SOUTH CAROLINA DEPARTMENT OF DISABILITIES & SPECIAL NEEDS

REQUEST FOR PAYMENT VOUCHER

REGION: ___ **PAYMENT MONTH:____,20___**

Provider's Name: ___ **Provider SSN or Fed. ID #: .**

Address: ____ **PO # _**

VENDOR #_____

Applicant's Name	SSN	Type of Service	SCDDSN Rate	Amount Due
		Monthly Payment	$	$
		One-Time Payment	$	$
		Monthly Payment	$	$
		One-Time Payment	$	$
		Total DDSN Funds Requested		$

FUNDING CODE#:

I hereby certify that the above information represents the actual expense incurred for services received.

_____ _____

(Date**)** **Signature of Provider**

_____ _____

(Date**)** **Director of Service Coordination**

_____ _____

(Date**)** **Director of Community Contracts**

REVISED: 8/28/95